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COMMUNITY STREET WORKER REVIEW AND EVALUATION

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Medical Officer of Health

MARCH, 1984

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Local Board of Health May 14, 1984

COMMUNITY STREET WORKER REVIEW

> "The tuberculosis death rate in skid row is 36.9 times higher than for comparable males in the U.S. population. Heart disease is 23.3 times higher; pneumonia death rates 14 times higher; accidents from falls are 15 times higher and suicide is 5 times higher than national rates." (1)

Nurses responsible for delivery of public health service in the early 1970's in the Moss Park district of the City of Toronto, noted an increase in the number of male adults who suffered severe infestations of head and body lice and scabies as well as tuberculosis. Controlling these infections has always been difficult in a transient population, who seem to find their way in and around the downtown "skid row" area (2).

To complicate the communicable disease problem further, many of the clients appeared to have drinking problems. "Pulmonary tuberculosis figures prominently amongst the diseases of chronic alcoholics ... Their lifestyle makes them particularly difficult patients for any long-term management of T.B." (3). Nursing staff, while trying to rid the community of communicable diseases, found it nearly impossible to assist these elusive and often uncooperative community members with the very problems they had been contacted to solve.

BACKGROUND

The goals for the four-year clinical demonstration project (Appendix I (a)) were to enable the Public Health Nursing Division of the City of Toronto Department of Public Health to:

1. Delineate and clarify the needs of this specific population.
2. Decrease the rate of communicable disease within this group.
3. Determine the Department's future role in assisting this specific population.

For the purpose of this paper "skid row" may be defined as:

> "Any old dilapidated street or section of a town containing very cheap bars, eating places and flop houses where the permanently unemployed, vagrants,

> beggars, petty criminals, derelicts, degenerates, and mainly unemployed, alcoholics hang out" (2).

In searching for the suitable candidate to take on the challenge of working with a specific and complex caseload, criteria were established to assist the interviewers in their selection process. Perhaps most important was to elicit an accepting and nonjudgmental attitude on the part of the qualified health professional who would have to assist clients with both health and social problems. Further, the attributes of patience, tact and determination would be needed to help a hard-to-reach population. The assignment would lead the community street worker into parks, alleys, bars and squalid rooms in run-down tracts of housing in the City's known skid row area.

The four-year community street worker clinical demonstration project was exploratory in nature, in that it sought to identify the characteristics of a socially isolated population who possessed a communicable disease and may also have had an alcohol-related problem. This population was in need of health care and for a variety of reasons did not receive it, because: 1) they may not have known how to access the health care system as it existed in this City; 2) they chose not to access and utilize the traditional system; and/or 3) they were rejected by the health care providers because they are uncooperative, unable to pay, and viewed as objectionable, repulsive, etc.).

LITERATURE REVIEW

Several early published works exist on the subject of homeless men. These papers date back to the beginnings of the 20th century and are included in Robert Straus' definitive work on "Alcohol and the Homeless Man, 1946" (4).

> "One Thousand Homeless Men, by Alice W. Solenberger is an analysis of case records of 1,000 men who applied to the Chicago Bureau of Charities during the years 1900-1903. Data also presented from case records of 200 men who applied to the Associated Charities of Minneapolis in 1910.
>
> "Why There Are Vagrants, by Frank C. Laubach. This study, made in 1916, was based on questionnaires and interviews with 100 men contacted while they were working in a woodyard operated by the Charity Organizations of the City of New York.
>
> "The Hobo, by Nels Anderson. Subtitled The Sociology of the Homeless Man. This study was an overall attempt to

> portray the way of life, personality traits and problems in Chicago's homeless male population in 1923.
>
> "Twenty Thousand Homeless Men, by Edwin H. Sutherland and Harvey J. Locke. This study was carried out in 1934 and 1935 among men living in the Chicago shelters of the Service Bureau for Men. The field work was done by a group of social scientists who were seeking a better insight into the life experiences and attitudes of the men."

While the subject of homeless men has been researched in some detail in the U.S.A. and England, specific health problems linked with the complexities of homelessness appear to have been ignored by early researchers as they related to health status. In 1946, Straus, however, did briefly address the physical problems tied to alcohol and the homeless "... due to lax living habits, the alcoholic is often in poor physical condition and susceptible to a variety of diseases" (4). In 1963, Bogue concluded that the skid row men he studied in Chicago were unable to manage in society due to poor physical and mental health. He blamed this on the lack of accessibility of this population to existing medical and psychiatric services, due to poverty and other social reasons (5).

In 1969, Schmidt and de Lint showed in their Canadian study that death rates from pneumonia were three times greater in alcoholic men and seven times greater in alcoholic women than in the general population (6). Blumberg pointed out that: "many skid row men are sick and in need of care; much of the prevalent disease appears to be chronic ... These men are unlikely to seek out medical care ... they discourage easily and are frustrated by the smallest obstacles, such as the need to wait to see a physician or nurse; to fill out forms; or to return a number of times for various exams. It is clear that tuberculosis frequently develops while a man is living on skid row. This may come about through an alcoholism to malnutrition to a tuberculosis cycle ..." (7).

Further, a strikingly smaller number of authors attempted to identify any successful model of treatment for health problems for those who suffer communicable diseases and drinking problems. One study did attempt to address the issue of ensuring that patients with tuberculosis comply with prescribed therapy by assigning nurse practitioners to clients with communicable disease. "The key to the success of the program is direct patient supervision. Due to the related problems of alcohol and drug abuse that often accompany the disease, compliance has always been the most difficult problem in any T.B. therapy program. We have overcome this problem by using nurses to ensure compliance" (8).

METHODOLOGY

No evaluation component was built into the original community street worker program proposal in 1978. It therefore became necessary to develop strategies to collect relevant data in order to attempt to measure change in level of illness and wellness in the specific population being served. The author is indebted to Ms. Lynn Elinson, Epidemiologist, Community Health Information Section, Department of Public Health for her invaluable assistance in 1981, in developing a data collection tool (Appendix II) in which the community street worker was able to collect data after each contact with each client in his caseload.

Secondly, the epidemiologist assisted the author in developing a brief questionnaire to be sent to selected internal/external health professionals who had opportunities to know of the work of the community street worker. The purpose of the questionnaire was to elicit answers from internal/external health professionals as to their knowledge and understanding of the community street worker project, the amount of time they had known the community street worker and the value they placed on the intervention of the community street worker with a specific clientele.

Ms. Catherine Pepper, Information Centre Assistant, Community Health Information Section, Department of Public Health also provided invaluable assistance by acquiring difficult to locate reference materials for the community street worker review.

LIMITATIONS

The known limitations of this project must herewith be recognized and identified. No scientific evaluation component was built in, designed or required at the time the request was submitted and subsequently funded. Furthermore, no comprehensive scientific body of knowledge appears to have existed, or even now exists, in relation to dealing with original goals of this project. Further, other limitations may exist unknown to the author of this paper.

FINDINGS

The findings of this paper are limited to a 13-month period spanning 1981-1983.

Eighty-two client records (79 male & 3 female) were examined retrospectively for data collection, and 2,498 contact visits were made with new and repeat clients during that 13-month period. The number of visits per client ranged between 1 and 98 return visits (Appendix III). While only 1 client required 98 visits, 4

required 28 visits each and 2 required 24. This high number of visits per individual speaks clearly to the chronic, complex health and social needs of this specific population. Country of birth data revealed that 72 clients were born in Canada.

The data revealed that clients' age-range spanned 25 to 75+ years, with 34.15% being identified between 55 and 64 (Appendix IV). This is of interest because people in the 50+ age group generally find it most difficult to find work.

While 82 clients lived across the census tracts within the City of Toronto (Appendix V), the largest percentage continued to prefer to reside in the old inner-City core. Further, it is important to note that the number of address changes recorded during the evaluation period is astonishingly low (Appendix VI). Seventy-one clients did not relocate at all during the two years while nine moved once during that time, one three times and one four times. It is the community street worker's hypothesis that the clientele he has been working with are no longer "skid row" population, in that they are so physically debilitated that they are no longer healthy enough to move on. A further comment should be considered in that our social service system encourages our population to "stay put" residentially in order to ensure smooth regular receipt of social welfare benefits.

Frequency of communicable or other diseases seen by the community street worker on the first visit with clients appears high; but must be seen in the context of the established criteria for taking on new cases. Fourteen clients (17%) presented with pediculosis, one (1.2%) had scabies and forty-four (53.6%) had diagnosed T.B. at the time of the community street worker's assessment. To add to the complexity of the health assessment, forty-nine clients (59.7%) appeared to have a "severe" alcohol problem and twenty-eight (34.1%) a "moderate" alcohol problem. Note: for the purpose of this study, the community street worker defined the degree of alcoholism as:

Severe

Unable to control drinking or be responsible for his actions, even to the exclusion of paying rent, purchasing food or taking medications. Filthy appearance and living in squalor.

Moderate

Accepts some responsibility for actions. Drinking has been a problem or goes on occasional binges (around cheque time), but pays own rent, purchases some food and remembers to take medications most times. Occasionally washes, changes clothes and cleans room.

Only five did not appear to have a alcohol problem.

Number of meals eaten each day at the time of the first visit reported by the client indicate that seven ate one meal a day, sixty-two said they ate twice and seven said they ate three times daily. What contributes to a "meal" is worthy of note, i.e., prepackaged products, bread/cold meat as reported by the community street worker. Further, many "eat out" as they are on the street during the day, if they are able. Eating out may be a double cream/double sugar coffee and donut at the local donut shop.

Due to the intervention of the community street worker in this project, the quality of some meals taken "at home" by the client has been upgraded by arranging for clients to have "Meals on Wheels"; and those who go out may have a meal of soup, etc., at the Scott Mission, Seaton House, Salvation Army and other like refuges. The living conditions that clients found themselves in were assessed by the community street worker at the time of the first visit. Many were living in unclean conditions with very limited personal space. Bathroom and kitchen facilities were often inadequate in that they were unsanitary and shared by more then two persons.

As many of the clientele required prescribed medications for a communicable disease or chronic health problem, it was necessary that the community street worker monitor the client's taking of same. Over the time-frame of evaluation, the community street worker noted that less than 25% of clients had been either willing or able to take medications on a prescribed basis. Therefore, it has all too often been necessary for the community street worker to visit the client daily and assist in the supervision of the client taking her/his medications. "The T.B. patient who is also an alcoholic presents a particular problem in that he is likely to interrupt his chemotherapy" (10, 11). Edsall, Grzybowski and co-workers cited the incidence of alcoholism among patients with reactivated pulmonary T.B. and implicated interrupted chemotherapy as the major factor leading to reactivation. Further, assistance was required in getting clients to medical appointments. At the time of the first visit the community street worker found that 35 clients were taking prescription medication of some type. The community street worker noted that some clients did not keep scheduled appointments with medical doctors, hospital clinics

and/or x-ray. As 31 appointments were missed by 14 clients, the community street worker rescheduled and accompanied 17 clients to individual appointments. On an ongoing basis he had to arrange and accompany 1 client to 14 appointments over the 13-month period of the evaluation.

During the 13 month data collection period 7 clients (9%) died. Specific causes of death were listed for 3 only as:

1. Acute myocardial infarction.

2. Traumatic pneumothorax.

3. Multiple and unspecified wounds of lower limbs.

More specific detailed information was not available, but it is interesting to note that 2 of the 7 may have died violently. Further, the community street worker was aware that of the 7 clients who expired, 1 died of accidental burns caused by lighting a cigarette after spraying himself with an aerosol disinfectant. A second man had a "seizure" where he resided, and subsequently died in hospital. The client was taking dilantin for epilepsy induced by alcoholism.

Research by Bogue has pointed out that mortality rates amongst "skid row" populations are related to prevalence of disease, accidental deaths and murders. He noted further that "skid row inhabitants can expect to live less than 1/2 the number of years remaining to men of the same age in the general population" (1). The high percentage of deaths within the sample reviewed, supports Bogue's observations that life on skid row has unsavoury features that are reflected directly by a high death rate.

The purpose of sending out the questionnaire (Appendix VII) to 24 internal/external health and social service agencies, was to elicit professional knowledge and awareness of the community street worker and the project in which the community street worker was involved. Of the 24 mailed, 20 were returned - 19 of which stated they did know of the community street worker. Only 1 had known the community street worker for less than 2 years, and further, all had worked with the community street worker a minimum of twice, save the one who had known the community street worker less than 2 years. Sixteen stated they had worked with him 7-12 times or more.

With regard to understanding the work of the community street worker, the greater number of respondents had some degree of comprehension about his work. Responses included: 1) "health promotion and disease prevention in the noncompliant individual who requires much encouragement to maintain a somewhat healthy

lifestyle"; 2) "predominantly male clients with communicable disease and frequently associated alcoholism, the community street worker tries to maintain/rehabilitate clients so that they can function at a more optimal level of health in the community" and 3) "the community street worker goes into areas where the average person would not go, working with less fortunate undesirables in the community".

All respondents worked with the community street worker in a health or social service related agency capacity with all 19 respondents replying positively to Question #6, explaining in essence that the service provided was one that no one else had been able to provide to date.

Question #7 elicited responses such as: "It is my opinion the community street worker like ... is desperately needed"; "This is a very difficult population and the community street worker has provided an excellent service that has contributed to clients keeping appointments"; "If the community street worker did not track down these clients, and subsequently get them to a treatment facility, T.B. would be spread to many more people". "This program is a must. I found the community street worker cooperative and extremely conscientious and very much needed by the people he has/is helping".

While the questionnaire is in no way scientifically objective, and conclusions cannot be drawn about the comments, it is notable that professional colleagues both within/outside health service agencies identified the importance of the role of the community street worker, if only to assist in the reduction of tuberculosis in this susceptible population. It had been the hope of the original proposal that a new and innovative model of treatment might be developed during the four years of this clinical demonstration project. Regrettably, the community street worker found the clientele he served and serves, either unable and/or unwilling generally to follow any course of treatment unaided. The number of interventions required to get clients to take medications or attend appointments appears to preclude setting up a "storefront treatment centre". Indeed, the community street worker found that most of his clients were completely unable to arrange any activity other than sleeping prior to noon. Subsequently, most of his work hours have been in late morning through early evening. He has spent innumerable hours assisting clients with social service problems as well as health problems (Appendix VIII).

The following two case studies illustrate the complexities of this population.

Case History #1

I was asked to trace JAMES B. by the T.B. & R.D. Section because he had missed his last two check-up appointments.

Jim is a 49-year old alcoholic with epileptic complications who falls frequently and suffers memory loss. His face bears many scars from falls and beatings. He was once mugged by assailants wielding baseball bats and he required plastic surgery.

He is small of stature, inoffensive, a loner and, therefore, frequently picked on. His life is a series of crises.

When sober he is quite cooperative and will attend appointments. He is difficult to keep track of because he quite often "loses" his welfare money and is evicted for nonpayment of rent. His diet is totally inadequate due to lack of funds and he sometimes goes days without food unless he is given something by his drinking buddies. Usually they, in an apparent attempt to buy friendship, have had his money because "their need was greater than mine".

His most recent crisis included a fractured skull and wrist and numerous facial lacerations. I arranged transportation to hospital via ambulance. He was detained at Wellesley Hospital for ten days then transferred to Riverdale.

His health and outlook improved considerably during this period and I decided an attempt should be made to rehabilitate at this time. An appointment was made with Cityhome and I signed him out of Riverdale on an afternoon pass. A suitable room was found and all necessary documentation was completed.

He was allowed to stay at Riverdale until his next welfare cheque, and this time it was used to obtain clothes and bedding. In cooperation with social services at both Wellesley and Riverdale, the ground work was started to find something to occupy his time during the day.

Upon his discharge from hospital on May 16th, he was taken to pick up his cheque, open a bank account, pay his rent, obtain groceries and move in. Jim was nowhere to be found on the following Monday. I eventually traced him back to his old address, where he had spent part of the weekend.

Since then he has spent more time there than at his new address. When last seen he had had further falls, his face was bloodied and his rent unpaid. I have established at the bank that he has insufficient funds to cover his rental cheque. The next crisis has begun.

Case History #2

My first contact with FRED W. was shortly after his discharge from hospital after suffering a fall. He was admitted for observation with minor head injuries.

My main concern was that this 69 year old alcoholic man was drinking heavily due to loneliness and depressing living conditions. He was one of two tenants in a private rooming house that had been vandalized by previous tenants. The landlord was not inclined to do any repairs.

Fred had already been mugged a couple of times late at night and I was concerned for his safety. After several visits he reluctantly agreed to move if a suitable room could be found. An appointment was made with Cityhome and a subsidized ground floor room eventually received his approval in the Parliament/Wellesley area.

By moving day he had changed his mind and the benefits had to be resold before he reluctantly agreed to move.

He has taken considerable pride in this room and has gradually added drapes, broadloom, furniture, television and a telephone.

I have attempted to lessen his medical discomforts (vertigo, gastritis, arthritic pain) by introducing him to a local physician. Numerous appointments were made for tests and they were either missed because of insobriety, a change of mind, disgust with the medical profession ("bunch of quacks"), or inability to sit and wait his turn. I soon discovered that I had to take and stay with this client until tests or examinations were completed.

As soon as it is mentioned that his neuropathy is alcohol-related he storms out and the process starts all over again with a different physician or family practice.

My role has become a supportive one. I encourage him to eat on a regular basis, take his medication, try to reduce his alcohol intake and amount smoked. He very seldom takes his medication as prescribed but he does appear a little more trusting.

This former merchant navy captain is divorced and had not had contact with his son or grandchildren for ten years. I phoned his son in Montreal and suggested that he send a Christmas card. They are now communicating on a cautious basis and there is the possibility of a visit if Fred can restrain himself and not be abusive over the phone about the past.

CONCLUSIONS

The goals of the community street worker/clinical demonstration project were to:

1. Delineate and clarify the needs of this specific population.

2. Decrease the rate of communicable disease within this group.

3. Determine the Department's future role in assisting this specific population.

The community street worker, with the assistance of internal/external health professionals and the Department's epidemiologist, was able to meet the first goal and found the population's needs to be multifaceted and chronic in relation to both their health and socioeconomic status. The second goal was partially met, in that the community street worker was able to reduce and/or rid some of his clients of their communicable disease, and thus enable them to live more comfortably. The third goal was enhanced in principle by Recommendation 1.12 of Public Health in the 1980's:

> "Follow-up with uncooperative and alcoholic TB patients living within the community remain an important responsibility of the Department, as such patients continue to represent a real threat to health."

This was also given practical reinforcement by the positive statements elicited from internal/external health professionals responding to the mailed questionnaire (as noted in the findings on pp. 4-8).

The need for this position to be made permanent was further reinforced by Executive Committee Report #24 (May 16, 1983) which approved funding for this program in the 1983 City of Toronto Operating Budget Estimates.

Both the literature and data point to the need for appropriate support services being made available to this specific population who are at risk for carrying and spreading communicable disease. Cumming addressed the need for a humane approach in servicing these complex clients:

> "It does seem that if we cannot cure them, that is persuade them to conform to our standards, ... we might at least offer them medical care, food and tolerance for their nonconforming lifestyle (12)."

The success of this clinical demonstration project has been due in large measure to the personal humanity of the community street worker, working on a one-to-one basis with a high risk, noncompliant population.

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Local Board of Health

May 14, 1984

APPENDIX I (a)

PROGRAM OBJECTIVES
(SLIGHTLY REVISED FROM 1978 SUBMISSION)

1. To reach a segment of the community that is not served at present.
2. To provide health care in the community for some of the hard-to-reach.
3. To achieve better control of communicable disease.
4. To provide a model of treatment for the transient, alcoholic, or tuberculosis patient. This would be channelled to those who fail to carry through on their medication regime.
5. To provide service for extended hours.
6. To improve the image of the public health nurse.
7. To become more aware of the community needs.

RE COMMUNITY STREET WORKER CASELOAD

Inclusion criteria for selection:

1. Should be a person who for some reason (such as alcoholism or mental disorder, etc.) cannot complete a treatment regime for communicable disease, e.g., tuberculosis, pediculosis, scabies, V.D., etc.
2. Male or female adult - over 18 years of age.
3. Transient.
4. No regular family ties.

APPENDIX 1 (b)

CITY OF TORONTO
DEPARTMENT OF PUBLIC HEALTH

August 30, 1978

To: Local Board of Health

Subject: Community Street Worker

Origin: Medical Officer of Health, today's date (c37h1th78068:37)

Comments:

For some time it has been evident that there is a type of person in the City core who is usually male, socially isolated, transient within a small geographic area, and has chronic problems which include alcohol abuse and tuberculosis. These persons would normally be the concern of social agencies, hospitals and volunteer groups, except for the fact that their lifestyle causes them to be a reservoir of some ailments of concern to this Department.

The Department has been especially concerned with the incidence of tuberculosis in the area between University Avenue and the Don River, which has the highest rate in the City of Toronto. There appears to be many reasons for this, such as failure of patients to complete a regimen of medications, failure to keep clinic appointments, a transient population that makes it difficult to do adequate follow-up, poor and crowded housing conditions, and alcoholism.

In the past five years, there has also been an increase in the number of adults, particularly male, who have had severe infestations of head lice, body lice and scabies. The control of these infections is difficult and it is felt that a more concentrated outreach to these individuals is necessary to provide treatment and work more effectively with them.

As a result of the growing concern for the health problems in this area, the Department submitted a request for a Community Street Worker in the 1976, 1977 and 1978 Program Change Statements. Although the concept received support in 1976 and 1977, due to

budget constraints, the program was not approved for funding by the Budget Review Group until 1978.

The unique aspect of this project lies in its concentration on a relatively small number of individuals and the intensity of follow-up so that these individuals are moved into a state of improved health and maintained in that state. In the past, the demands on public health nursing services from other sectors have precluded this as each individual required a tremendous amount of time before any results were obtained. One additional constraint has been the primarily daytime nature of the Department's services which restricted contact with these individuals. This will be overcome by providing service adjusted to the hours of the client.

It is anticipated that this will be a four-year pilot project which will be evaluated in the third year according to results achieved. Some suggested questions to be considered in the determination of evaluation criteria are outlined in Exhibit A.

It is proposed to establish the temporary position of Community Street Worker for a four-year period. A proposed job description is attached to this report (see Exhibit B) and it is recommended that the job be placed in the salary range, $14,579 - $16,681 (1977). This would be a Union position, and subject to review by the Job Evaluation Committee for appropriateness of salary and description. Discussions will be held with Local 79 to ensure that the hours of work for this position are held flexible.

Recommendations:

1. That the Community Street Worker program be approved, with a four-year evaluation period commencing on the date of appointment of the successful candidate.

2. That the position of Community Street Worker (Temporary) be added to the establishment of the Public Health Nursing Division, at the salary range $14,579 - $16,681 (1977), subject to review by the Job Evaluation Committee. (See Exhibit C.)

3. That the Medical Officer of Health, in consultation with the Executive Director, Management Services Department, be authorized to take the necessary steps towards the appropriate presentation to the City Executive Committee.

(signed)
Medical Officer of Health

September 28, 1978

To: Executive Committee

Subject: Change in Establishment - Department of Public Health - Community Health Worker, Outreach Health Program Pilot Project

Origin: Executive Director, Management Services Department and the Medical Officer of Health, Department of Public Health, September 28, 1978 (c10exec78155:118)

Comments:

Over the past few years there has been an increase in the number of cases of tuberculosis, alcoholism, head and body lice, and scabies among the adult male transients in the City core area. The Public Health Nursing Division has found that they cannot provide the substantial amount of time required to deliver health services to this group, within their regular work schedule. In addition, the target population is reluctant to take advantage of the health services and facilities which are available. It is felt that a more concentrated time-flexible health service to these individuals is necessary, to provide effective long-term treatment.

It is proposed that a four year "pilot project" be initiated to provide an outreach health service to accommodate these individuals. This service would include supervision of medication, assistance with clinic appointments and the carrying out an advocacy role on their behalf. The program will be evaluated early in the fourth year and a report prepared by the Biostatistician in the Administration Services Division. This report will include a review of cost/effectiveness, efficiency, and recommendations on the continuation, expansion or termination of the program. Some suggested questions to be considered in the determination of evaluation criteria are outlined in Exhibit A.

It is proposed to establish a temporary position of Community Health Worker to carry out this program for the four-year evaluation period. A proposed job description is attached to this report as Exhibit B.

We have reviewed the projected program requirements with the Public Health Department and concur with the creation of this program.

Recommendations:

1. That the Community Health Program be approved.

2. That evaluation of this program take place in the fourth year of the project.

3. That the establishment of the Department of Public Health be increased as follows:

Position	Annual Salary	Union Affil.	Hrs/ Week	Estab. Incr.	Incr. at Max. Annual Salary
Community Health Worker (Temporary)	$16,370-18,398 (1977 Rates)	79	35*	1 (Temp)	$18,398

* (The 35 hour work week will be on a flexible basis to include evenings and weekends, as required)

4. That this position be filled by open competition.

This establishment change has been discussed with and agreed to by the President of C.U.P.E. Local 79. The Job Evaluation Committee have reviewed the new job description and subject to confirmation upon implementation of the Job Evaluation Program, support the proposed wage rate.

This establishment change has been reviewed and funds were approved during the Program Change phase of the 1978 Budget of the Department of Public Health.

It is expected that this program will be approved for inclusion in the Ontario Ministry of Health 25% Public Health Subsidy Program.

Exhibit A

Suggested Questions to be Considered When Determining Evaluation Criteria

1. How many individuals are there in the selected area, who require treatment under this program?

2. How much time is required to deal with all of an individual's short-term problems and get him/her onto a program of maintenance and rehabilitation?

3. How much time is required to keep an individual on a program of maintenance and rehabilitation? (The answer to this question and the preceeding one will facilitate an estimate of how many Community Street Workers would be needed to extend the program to all or part of the City.)

4. Is it of value to deal with a few of an individual's problems or must all problems be dealt with for anything of positive significance to be achieved?

5. Is this approach more effective than that employed elsewhere in the Department?

6. How much does it cost?

   - overall

   - per individual

   - per problem

7. Is this approach more or less expensive than that employed elsewhere in the Department?

Exhibit B

Community Street Worker (Temporary)

(Local 79)

Work Illustration

The employee in this position is required under the direction of the District Public Health Nursing Supervisor, to carry out a four-year pilot project to improve the health status of a predominantly male group of approximately 40 - 60 socially isolated transients within the City core. Ensures that all identified medical problems such as tuberculosis, alcoholism, body lice and scabies are brought under control, by arranging for treatment or by actual administration of prescribed medication, and endeavours to maintain this improved state of health. Carries out an advocacy role on behalf of the individual in conjunction with other community workers. Assesses the health needs of this group and plans an appropriate program. Provides service at hours most convenient for reaching these individuals including weekend and evening hours. Responsible for reporting on the effectiveness and efficiency of the project in yearly progress reports, with technical help from the Department's Biostatistician. Provides input to the final evaluation report to be completed early in the fourth year of the project by the Biostatistician.

Minimum Qualifications

Registered Nurse in the Province of Ontario with one of the following: Baccalaureate Degree from a University School of Nursing which has included public health nursing; Certificate in Public Health Nursing attained by at least one year post-graduate study at a University School of Nursing or School of Public Health; Registered Nurse with acceptable educational qualifications or experience. Ability to organize, evaluate and report on a pilot project. Working knowledge of community health care resources. Respect for the client population, with the ability to win the trust of disadvantaged and poorly-motivated individuals. Ability to create innovative ways to deliver service.

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APPENDIX II

COMMUNITY STREET WORKER PROJECT
HEALTH STATUS ASSESSMENT

Date of Visit: _____ Length of Time of Visit: _____
Name of Client: _____ Date of Birth: _____
Address: _____ Country of Birth: _____
Telephone No: _____ Sex: _____

Is this the initial assessment? (check) __ Yes __ No

A) HEALTH PROBLEM

	Please Check	Comments	Date of Diagnosis (if known)
Pediculosis	_ Y _ N		
Scabies	_ Y _ N		
TB	_ Y _ N		

Other (please specify) _____

B) NUTRITIONAL NEEDS

Number of meals eaten per day _____
Last meal eaten _____
Comments _____

C) ALCOHOLISM (please check)

_____ Severe
_____ Moderate
_____ Minor Problem
_____ Not a problem

D) HOUSING

1. Check if contained in living quarters:

__ STOVE __ REFRIGERATOR __ HOT PLATE __ KITCHEN SINK
__ TOILET __ BATHTUB __ SHOWER __ SINK

2. General cleanliness (check one) __ GOOD __ MODERATE __ POOR

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COMMUNITY STREET WORKER PROJECT
TREATMENT

I MEDICATION

NAME OF MEDICATION	AMOUNT	DATE OF PRESCRIPTION	TAKEN (If administered; x If taken independently; o If not taken)

II APPOINTMENTS

PHYSICIAN/ CLINIC	DATE OF APPOINTMENT	REASON	APPT. KEPT (If taken; x If taken independently; o If did not go)

III NUTRITION - How does client receive meals?

	Frequency	Check if Eaten	
__ Meals-on-Wheels	_____	__ Yes	__ No
__ Eats Out	_____	__ Yes	__ No
__ Prepares Own	_____	__ Yes	__ No
__ Other	_____	__ Yes	__ No

A) Contact with landlord/superintendent

Date	Reason	Outcome

B) Contact with Health Department Staff

Date	Position/Division	Reason	Outcome

C) Contact with Outside Agencies

Date	Agency	Reason	Outcome

D) Financial Status (please check)

Old Age Pension _ Y _ N	Arranged by:	_ Self _ J. Tracy _ Other
Welfare Benefits _ Y _ N		_ Self _ J. Tracy _ Other
Other _____ (specify)		_ Self _ J. Tracy _ Other
Independent _ Y _ N		

APPENDIX III

TOTAL NUMBER OF VISITS - GROUPED

TOTVISG	FREQUENCY	CUM FREQ.	PERCENT	CUM PERCENT
	1	.	.	.
Fewer Than 10	39	39	48.15	48.15
11-29	32	71	39.51	87.65
30-59	7	78	8.64	96.30
60 - 79	2	80	2.47	98.76
80+	1	81	1.24	100.00

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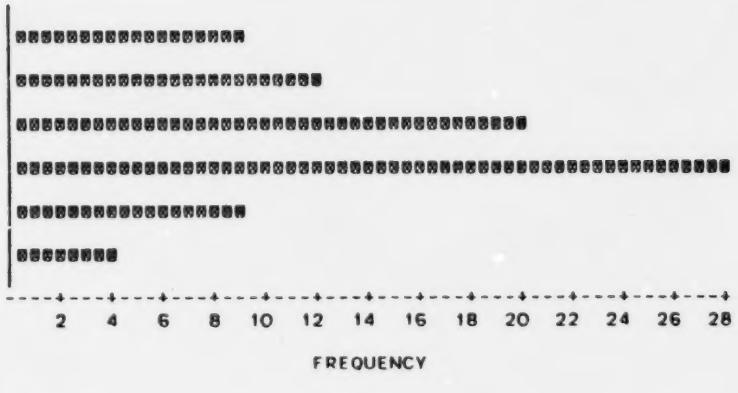
APPENDIX IV

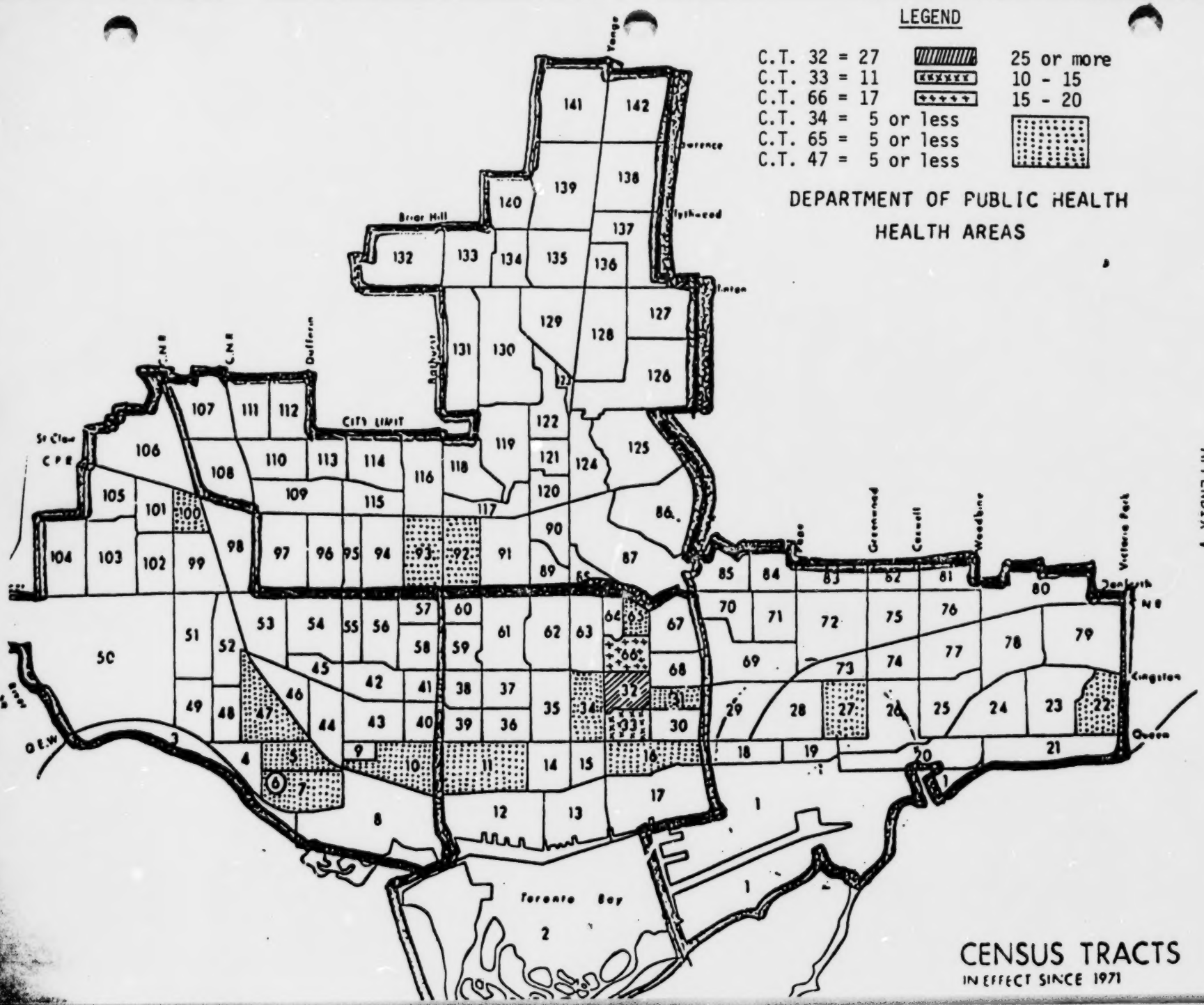
AGE DISTRIBUTION OF CLIENTS

FREQUENCY BAR CHART



AGEG	FREQ	CUM. FREQ	PERCENT	CUM. PERCENT
25-34	9	9	10.98	10.98
35-44	12	21	14.63	25.61
45-54	20	41	24.39	50.00
55-64	28	69	34.15	84.15
65-74	9	78	10.98	95.12
75+	4	82	4.88	100.00

APPENDIX V


LEGEND
C.T. 32 = 27
C.T. 33 = 11
C.T. 66 = 17
C.T. 34 = 5 or less
C.T. 65 = 5 or less
C.T. 47 = 5 or less
25 or more
10 - 15
15 - 20
DEPARTMENT OF PUBLIC HEALTH
HEALTH AREAS
CITY LIMIT
Toronto Bay
CENSUS TRACTS
IN EFFECT SINCE 1971

APPENDIX VI

NUMBER OF DIFFERENT ADDRESSES

ADDN	FREQ.	CUM FREQ.	%	CUM %
1	71	71	85.59	86.59
2	9	80	10.98	97.56
3	1	81	1.22	98.78
4	1	82	1.22	100.00

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APPENDIX VII

QUESTIONNAIRE

June 20, 1983

1. Do you know the community street worker for the City of Toronto, Department of Public Health?

   Yes _____ No _____

2. How long have you been aware of the Community Street Worker Project?

   _____ weeks
   _____ months
   _____ years

3. How often have you had an opportunity to work with the community street worker?

   _____ once
   _____ 2-6
   _____ 7-12
   _____ more often

4. What is your understanding of what the community street worker's job is?

   _____

5. In what way do you work with the community street worker?

   _____

6. Do you think the Community Street Worker Project is worthwhile?

   _____ Yes)
) explain
   _____ No)

7. Do you have any additional comments you wish to make?

   _____

Skid Road nurse cares for down-and-out of Toronto

By JUDITH KNELMAN

Jeff Tracy spends his days on Skid Road — in the Moss Park, Regent Park and Cabbagetown area — carrying a caseload unlike that of any other nurse.

"It's as though people have put on skids and slid right down. The people I work with are at the bottom. They're all on welfare, all permanently medically unemployable. They've been through all the other agencies — Alcoholics Anonymous, the Salvation Army, the Scott Mission — but they're beyond that now. Often they have no food, and they haven't got the strength to walk to the missions," he said of the men and women he sees daily.

He's into the second year of a four-year pilot project undertaken by the Toronto Department of Public Health to stop the spread of communicable diseases, particularly tuberculosis, lice and scabies. The idea is that raising the general standard of health of this group at the bottom of the social ladder will lessen the risk of communicable disease to the rest of society.

"We knew we couldn't cure alcoholism," Julia Shea, assistant director of nursing for the city, said. "But we felt if we could improve their health they might be able to do something about their other problems. So far it's too early to tell if the program will be adopted permanently, but if we can [illegible] and help their medical problems it should be worthwhile."

Mr. Tracy, 50, has a small caseload that is handled constantly and intensively. "If they show signs of making some effort to change, I'll give them as much support as I can," he said. "I'll see them twice a day if need be, though that's rare. I'll help them upgrade their accommodation, get bed linen for them, show them how to buy food sensibly, get them a haircut and shave.

"All I can do for them if they won't change, though, is see that they get to appointments for chest X-rays and medical examinations and take their medication."

Most of Mr. Tracy's clients have or have had tuberculosis. It is spread by droplet infection — in coughing or even speaking — and is especially prevalent in Skid Road, where many people share the same facilities and live at close quarters. Under the Public Health Act, people are required to take treatment for TB but they can't be forced to stay in a respiratory disease hospital until they're deemed ready to leave. Many disregard instructions to return every three months for a checkup after their release.

"You can perhaps get them to go once through the courts," Mr. Tracy said, "but you have to somehow impress on them that it's for their own good and for the protection of others that they should get treatment." The [illegible] Unit, if the group does not [illegible] use of the disease the health of the rest of the community is threatened.

For these people, remembering to visit a clinic or doctor at a particular time is an impossible task. "They can't tell what day of the week it is or what time it is," he said. Morning is whenever they happen to wake up — and most don't care whether they wake up, he said.

"Physically and emotionally they're in bad shape. They're malnourished, so they have no energy. Alcohol probably deadens the nerve endings in their tongues and their stomachs and their stomachs are full from the drinking. They'd rather drink than eat, but if they don't eat adequately they're susceptible to becoming re-infected.

"How do you convince people who have an income of about $240 a month and have to spend $130 to $150 a month for accommodation that they should spend what's left sensibly on food?" he asked.

Parasites are another problem. Unless they're treated, they multiply rapidly. Not only is it an annoying and uncomfortable affliction in itself but it can spread disease. Typhus, for example, is transmitted from human to human by the body louse.

"These men flake out on one another's beds and wear one another's clothes," Mr. Tracy said. Lice spread easily among them. They scratch and get infections and bleed. Sometimes their undershirts stick to their bodies from dried blood. The shirts have to be soaked off their backs at a delousing centre.

One of his cases was acquired when neighbors called because a man went outside, possibly to get bright light, dropped his pants and began picking lice off his body. "All the residents were filthy — they were all winos drunk at least half the time. But what they were complaining about was this man's exposing himself."

The man has since been deloused, given eyeglasses and moved to more reasonable accommodations. He takes care of himself and seems to derive some enjoyment from his life. But he is still visited periodically by Mr. Tracy. "You always have to keep an eye on these people," he observed. "The only ones I have discharged are those who have died."

Many of his clients disappoint him. "You can't count on them for anything," he said. "If you expect nothing, you're okay. I realized I wasn't going to be able to save anybody's soul. To get any co-operation I have to be very patient, not threatening, and tolerant."

He said he does what he can during the work day, then goes home and tries not to think about the sordid conditions he's seen all day. "The problem is so large and long-standing that I know I'm not going to change things to any great degree. There are a lot more people out there than I am able to reach."

Eric Christensen

Jeff Tracy talks to one of the men on his caseload in Toronto's Skid Road area. He tries to upgrade health of men there to lower risk of communicable diseases to rest of society.